DOCUMENT RESUME

ED 457 453 CG 031 222

AUTHOR Moorhead, Douglas A.
TITLE Efficacy of Nonpsychopharmacological Treatment for Male Sex Offenders: A Review of the Literature.
PUB DATE 2001-12-00
NOTE 66p.; Doctoral Research Paper, Biola University.
PUB TYPE Dissertations/Theses (040)
EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS Behavior Modification; Correctional Rehabilitation; Counseling Effectiveness; *Counseling Techniques; Literature Reviews; *Males; Outcomes of Treatment; Peer Counseling; Prevention; *Psychotherapy; Sexual Abuse
IDENTIFIERS Comorbidity; Relapse; *Sex Offenders

ABSTRACT

Sexual offenses have a serious impact on individuals and society at large. Most victims know the offender; few victims report the offense; not all reports result in arrests; not all arrests result in conviction; and not all convictions result in incarceration. This paper reviews the literature related to psychotherapeutic treatment of male sex offenders and examines recent research related to the essential components of successful, nonpsychopharmacological treatment utilizing the Relapse Prevention (RP) model of therapy. It begins with a discussion of the classification of male sex offenders. This is followed by a discussion on the history of treatment for sex offenders. The importance of assessment is explained in terms of the need for individualized treatment plans, in order to prioritize those waiting for treatment, and to screen those offenders who have a comorbid Axis I diagnosis. The review concludes that effective treatment requires a comprehensive approach. It explains how the RP approach differs from all other therapies and that its compassionate confrontational approach relies on motivational interviewing, group peer pressure, and effective supervision to increase the probability of success for the offender upon his return to the community. Several studies are reviewed that suggest treatment can reduce sexual recidivism. (Contains 51 references.) (JDM)

Reproductions supplied by EDRS are the best that can be made
from the original document.

ED 457 453

# EFFICACY OF NONPSYCHOPHARMACOLOGICAL TREATMENT FOR MALE SEX OFFENDERS: A REVIEW OF THE LITERATURE

---

A Doctoral Research Paper

Presented to

the Faculty of the Rosemead School of Psychology

Biola University

---

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Psychology

---

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
This document has been reproduced as received from the person or organization originating it.
Minor changes have been made to improve reproduction quality.
Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

by

Douglas A. Moorhead

December, 2001

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY
D MOORHEAD
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

CG031222

BEST COPY AVAILABLE

ABSTRACT

EFFICACY OF NONPSYCHOPHARMACOLOGICAL
TREATMENT FOR SEX OFFENDERS:
A REVIEW OF THE LITERATURE

by

Douglas A. Moorhead

The following paper examines the existing literature and research pertaining to the cognitive behavioral treatment of sex-offenders. It discusses the history of treatment leading up to current methods and the core components of the Relapse Prevention Model of treatment. This model is currently used in over 80% of existing sex offender treatment programs in the western world. Surprisingly, however, there are no truly scientific studies, with random assignment and control groups, supporting Relapse Prevention's efficacy. The studies published to date have been largely postdictive and/or poorly designed. The most informative studies have been meta analyses that provided static factors associated with relapse, but showed no predictive validity for dynamic factors such as treatment.

EFFICACY OF NONPSYCHOPHARMACOLOGICAL TREATMENT FOR MALE SEX OFFENDERS: A REVIEW OF THE LITERATURE

by

Douglas A. Moorhead

APPROVED:

Gary H. Strauss, Ed.D. Date 8/29/01
Gary H. Strauss, EdD

Joan W. Jones, PsyD Date 8/29/01
Joan W. Jones, PsyD

APPROVED:

Patricia L. Pike, PhD, Dean
8/29/01
Date

Copyright © 2001 by Douglas A. Moorhead

TABLE OF CONTENTS

PAGE

ACKNOWLEDGEMENTS ..... v

DOCTORAL RESEARCH PAPER

Introduction ..... 1

Defining Male Sex Offenders ..... 2

Classification of Offenders ..... 4

Legal classification ..... 4

Classification by nature of offense ..... 5

History of Treatment ..... 8

Psychoanalysis ..... 9

Cognitive-Behavioral Therapies ..... 9

Satiation therapy ..... 9

Aversion therapy ..... 10

Covert sensitization ..... 10

Relapse Prevention Therapy ..... 10

Assessment of Offenders ..... 14

The Polygraph ..... 15

The Interview ..... 16

Psychological Tests ..... 18

Physiological Tests ..... 18

Actuarial Assessment ..... 19

Effectiveness of Current Psychotherapeutic Treatments ..... 20

Furby, Weinrott, and Blackshaw ..... 21

Rice, Harris, and Quinsy ..... 24

Marques, Day, Nelson, and West ..... 25

PAGE

Barbaree, Seto, and Maric....28
Mander, Atrops, Barnes, and Munafo....30
Olsen and Aytes....33
Kennedy and Hume....35
Hanson and Bussiere....36
Reddon, Payne, and Starzyk....38
Moore, Bergman, and Knox....40
Polizzi, Mackenzie, and Hickman....41
Nicholaichuk, Gordon, Gu, and Wong....42
Conclusions....45
Future Directions....47
REFERENCES....53

ACKNOWLEDGMENTS

I would like to thank Amy, my beautiful wife, for her support over the last 4 years of graduate school and her patience during the writing of this paper. I would also like to thank Debi Smith, my editor, without whom this would not have been done.

# EFFICACY OF NONPSYCHOPHARMACOLOGICAL TREATMENT FOR MALE SEX OFFENDERS: A REVIEW OF THE LITERATURE

## Introduction

Sexual offenses have a serious impact on individuals and on our society, both emotionally and economically. One Colorado survey reported that there are 154,518 incarcerated male sex offenders in 43 states, an average of 26% of the population of the state prison system (Wenger, West, & Hromas, 2000). The cost of housing sex offenders in prisons and psychiatric hospitals in the U.S. is more than one billion dollars per year. Victims of sexual abuse are 6.4 times more likely to abuse drugs, 3 times more likely to be diagnosed with major depression, 6.2 times more likely to be diagnosed with posttraumatic stress disorder, and 13 times more likely to attempt suicide (U.S. Department of Justice, 2001). Most victims know the offender, few victims report the offense, not all reports result in arrests, not all arrests result in conviction, and not all convictions result in incarceration. Furthermore, the government remains uncertain about how the prison system can effectively treat and manage those who are incarcerated. An estimated 8% of rapes, 6% of child abuse cases, and 2% of incest incidents are reported, and 3%, 1.3%, and .5% of the respective perpetrators are convicted.

Considering the cost effectiveness of treatment for male sex offenders, an estimated 14% reduction in recidivism of offenders would save 3.98 million dollars per year in incarceration fees for every 100 non-recidivating prisoners (Donato & Shanahan, 1999). The savings in the incalculable costs to their would-be victims could be much greater. From an economic standpoint, these figures point to the need for an efficacious treatment (thought the success rate may never approach 100%).

This paper will review the literature related to psychotherapeutic treatment of male sex offenders and will examine recent research related to the essential components of successful, nonpsychopharmacological treatment of male sex offenders utilizing the Relapse Prevention (RP) model of therapy.

## Defining Male Sex Offenders

The Diagnostic and Statistical Manual of Mental Disorders-4th Edition (DSM-IV; American Psychiatric Association, 1994) includes the diagnostic categories of exhibitionism and pedophilia. However, the judicial system has a different focus and more inclusive categories by which to define sexual offenses and sex offenders. According to the American Psychiatric Association (1999),

> Human sexual behavior is diverse and is influenced by culture. In addition to the obvious role sexual behaviors play in the preservation of the species, its major functions for human beings are related to bonding, expressing emotions between individuals, and recreation. Cross-cultural studies show wide diversity in what may be considered accepted sexual behavior. However, some types of socially unacceptable sexual behavior

> are classified as unwanted conduct in every society. In the United States, sex offenses are generally defined by state and federal statutes and thus vary from jurisdiction to jurisdiction. Changing sexual mores are not always followed by new legislation, and this situation may result in the continuing presence of "blue laws" that reflect the values of the past. These laws are generally not actively prosecuted or enforced. Criminal sexual behavior may be predicted on various factors such as consent, age, kinship, type of activity, gender of the partner, use of force, or location of the activity. Thus the same behavior may or may not be defined as criminal depending on the context. (p. 1)

Although the American Psychological Association and the American Psychiatric Association focus on the behavior of the individual who commits the sexual act, the judicial system and law focuses on the violation of the rights of others. The DSM-IV focuses on abnormal thoughts and behavior that inhibit normal functioning in everyday life and impair interpersonal relationships to a significant degree. From a judicial standpoint, however, the distinguishing feature is performance of the sexual act with an individual who does not or cannot consent to participation. Examples include the victims of rape, voyeurism, and exhibitionism, as well as those who do not have the capacity or maturity to give consent (e.g., minors, mentally handicapped adults). For the purposes of this paper, sex offender will be defined as a man who commits a legally prosecutable sexual act involving another person. This definition is legally broad and includes less severe offenses such as phone harassment and

indecent exposure, as well as including the more commonly thought of offenses such as child molestation and forcible rape.

Carnes (1992) believes that male sex offenders have sexual addictions. From the addiction perspective, the offender considers sex to be essential, powerful, and simultaneously frightening. Carnes has explored patterns of out-of-control behavior, consequences paid, inability to stop, obsessions, and fantasies. He found similarities with other addictions and developed the foundation for the RP treatment model, which will be explored after a discussion of the classification of male sex offenders and how treatment providers have attempted to rehabilitate them.

Classification of Offenders

Several typologies have been used to further describe male sex offenders. Some classifications are made on a legal basis, whereas other classifications are made using the nature of the sexual offense.

Legal classification. Sex offenders are typically classified on a legal basis. Stoller (1975) defines "deviations" as acted out sexual fantasies that arise from threats to one's sexual identity. Mayer (1988) discusses the most common offenses (e.g., rape, pedophilia, incest, exhibitionism, voyeurism) that are the primary focus of treatment groups. He draws attention to definitional problems:

> Deviations, abnormalities, variations, aberrations, and perversions in human sexual behavior are endless in number and kind. Likewise, theories regarding the classification and causation of these behaviors are numerous and often contradictory. The result: confusion, which is further

> compounded by the current rise in social acceptance of aberrant behavior when such behavior, often and arbitrarily, is classified as victimless. (p. 1)

Although the law provides a clear definition of an offense, Abel, Mittleman, Becker, Rather, and Rouleau (1988) found that the classification of male sex offenders is not so easy. Of those who were incest offenders, 34% committed only incest offenses, whereas 66% committed both incest and non-incest offenses. Of the 66% who committed non-incest offenses, 44% sexually abused a nonrelated female child, 11% abused an unrelated male child, 18% committed rape, 9% committed voyeurism, 5% were involved in frottage, 4% were involved in sexual sadism, and 21% were involved in other paraphilias. Furthermore, 59% of the offenders had the onset of deviant arousal patterns during adolescence. Weinrott and Saylor (1991, as cited in U.S. Department of Justice, 2001) found that 50% of a sample of incest perpetrators reported molesting outside of the home, and Faller (1990, as cited in U.S. Department of Justice, 2001) found that 80% of a sample of sex offenders reported molesting more than one child.

Classification by nature of offense. Paraphilias are defined by DSM-IV as "recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving 1) nonhuman objects, 2) the suffering or humiliation of oneself or one's partner, or 3) children or other nonconsenting persons" (pp. 522-523). The DSM-IV list of paraphilias includes Exhibitionism, Fetishism, Frotteurism, Pedophilia, Sexual Masochism, Sexual Sadism, Voyeurism, Transvestic Fetishism, and Paraphilia Not Otherwise Specified. Since Masochism, Sadism, Transvestic Fetishism, or Paraphilia Not Otherwise

Specified do not, in and of themselves, constitute sexual offenses as defined by the law, they will not be included in this review.

Rape is defined as the crime of forcing another person to submit to sex acts, especially sexual intercourse (Soukhanov et al., 1992). A rapist is defined in a similar fashion, as an individual who has forced sexual contact with another individual against his or her will. Groth (1979) categorized rapists into the following three categories: Anger, Power, and Sadistic. Knight and Prentky (1992) refined earlier work in this area through statistical analysis and discovered four basic categories for rapists: Opportunistic, Pervasively Angry, Sexual, and Vindictive. Schwartz (1995b) provided another common categorization of rapists: Situational, Emotionally Disturbed, or Criminal. All of these typographies utilize the perpetrator's motivation as a categorical determinant. On the other hand, statutory rape is always sexual contact with a minor whether or not it is "consensual." Although statutory rape includes the previous definition of rape, it also includes sexual acts performed with an individual who has not reached the age of consent as determined by the judicial system. Though not universal, the age of permissible consent is generally accepted to be 18 years old. It assumes that the individual under that specific age does not have the ability to give an informed consent to participate in sexual contact with an individual above that predetermined age limit.

Pedophilia is defined as an adult's sexual attraction towards a child or children. In essence, this could be considered "child love" that includes a number of sexually deviant behaviors. Those with this compulsive sexual orientation find sexual gratification by using children as sexual objects. There

are two general categories of pedophiles: fixated and regressed. Fixated pedophiles are aroused by using children as sexual stimulants or by fantasies that include children in sexually arousing situations or activities. Regressed pedophiles are adults who are primarily attracted to same age peers, but who will substitute children as sexual objects when under stress or when they are unable to be in a same-age relationship. According to the Federal Bureau of Investigation's (FBI) typology, regressed pedophiles are immature, socially inept individuals who relate to children as though they were peers (Lanning, 1986). These individuals may be experiencing a brief period of low self-esteem and turn to their own children or to other available juveniles to gratify their sexual desires. The FBI further delineates differences between situational offenders using the following terms: morally indiscriminate, sexually indiscriminate, and inadequate. Pedophiles can also be categorized as heterosexual, homosexual, or bisexual offenders (Mayer, 1988) or as endogamic, psychopathic, psychotic, drunken, pedophilic, mentally defective, and situational (Meiselman, 1978).

Incest offenders (those who molest within their own families) are also considered a separate category of offenders. They typically have a primary sexual orientation towards adult women, but substitute young (often female) family members (i.e., daughters, nieces) for mature sexual partners (Mayer, 1988).

Exhibitionists expose their genitalia to strangers (usually women or children) with the intention of instilling fear and shock in their victims and thereby causing sexual arousal in the offender (Mayer, 1988). Conversely,

voyeurs are aroused during covert observation of others who are naked or involved in sexual activities. Voyeurism, also called scoptophilia or peeping tomism, is almost exclusively attributed to men, often accompanies exhibitionism, and rarely exists without heavy pornography use and other paraphilias. Mayer states, "It is agreed that a relationship exists between pornography, striptease shows, group sex, and voyeurism" (p. 15). Laws focusing on this category of offense have been established to protect society from deviant predators. The goal of treatment for all sex offenders is to help these individuals develop appropriate sexual desires or learn to have greater control over their existing deviant sexual arousal patterns.

## History of Treatment

The history of sexual offenses extends back to the beginning of written records; however, changes in society have greatly impacted the treatment of sex offenders. One of the earliest forms of treatment was to stone the offender to death (Zodhiates, 1990). To date this approach seems to be the most effective and the only treatment with an inherent guarantee to prevent another victimization by that particular offender. In the last century, other treatment plans have been implemented with varying degrees of success. Today there are as many treatment modalities as there are psychological theories, and they include a broad range that includes chemical castration, masturbatory satiation, reality therapy, individual therapy, and RP therapy, among others.

Psychoanalysis

According to Barnard, Fuller, Robbins, and Shaw (1989) psychoanalysis presented one of the earliest attempts to understand and treat sex offenders. From the Freudian perspective of psychosexual stages, their behavior is indicative of an integral and complex set of character deficits that are the result of significant childhood trauma. These individuals are attempting to work out their ensuing intrapsychic conflicts through the commission of sexually deviant acts against others. Various theorists have speculated that offenders have castration anxiety, are reacting to seductive mothers, have inadequate superegos or egos, are reenacting their own sexual trauma, are confusing their aggressive and libidinal drives, or had narcissistic self-representation as children (Schwartz, 1995a). In therapy, offenders must work through intrapsychic conflicts, express repressed pain, and experience a healthy recapitulation of the primary family experience through the therapist.

Cognitive-Behavioral Techniques

Several cognitive-behavioral approaches have been used in the treatment of sex offenders. Each has slightly different goals and implements different techniques that are aimed at changing the individual's deviant behavior.

Satiation therapy. Marques (1970) defines satiation therapy as treatment that involves the use of appropriate stimuli for masturbation to the point of ejaculation. Once ejaculation occurs, the offender is required to masturbate for as long as an additional hour to his deviant fantasies. Although many offenders (especially child molesters) frequently have difficulty maintaining arousal with appropriate stimuli, they can often learn to overcome this difficulty through the

process of "thematic shifting." They are allowed to begin arousal using deviant fantasies and learn to shift to appropriate sexual fantasies prior to ejaculation.

Aversion therapy. A totally different approach has been articulated by Tollinson and Adams (1979). Aversion therapy utilizes negative reinforcement paired with the offender's deviant sexual arousal. Immediately after the offender views a picture of a nude child or a picture of a violent sexual act, they are given a chemical agent that causes nausea and vomiting, or are presented with an odiferous agent such as valeric acid, or are presented with a faradic or electrical aversion (i.e., an electrical shock).

Covert sensitization. Dougher (1995) describes one type of cognitive treatment that utilizes covert sensitization in which the offender is taught to counter condition his deviant arousal pattern. The therapist uses guided imagery by repeatedly reading the offender's deviant sexual fantasy (e.g., a fantasy written by the offender) and immediately following with imagining dire negative consequences for the sexual act. The effects of the negative consequences can be further enhanced by the simultaneous presentation of a unpleasant olfactory stimulus if the offender cannot create sufficient negative mental imagery. The imagination and/or presentation of the negative consequence is continuously moved up in the presentation of the offender's fantasy starting at the end and gradually brought to the beginning of the fantasy after a period of time and sessions where the two were continuously paired.

Relapse Prevention Treatment

In relapse prevention (RP) treatment, sex offenders are considered to be similar to chemical addicts in that they are addicted to deviant sexual activity

and need education, group support, and confrontation. This model, in fact, began as a treatment approach for alcohol abuse (Marlatt & Gordon, 1985). By educating the offender about the damages of sexual offenses, socializing them to age-appropriate peers, and identifying triggers or emotional cues that may be indicative of the impending commission of another offense (i.e., relapse), proponents of this approach ultimately hope to protect society by the diminution of future offenses. Incarceration, on the other hand, is intended primarily for the purpose of punishment and only secondarily as protection for society by removing the offender from access to the public. At this juncture, treatment and incarceration often overlap, which is critical for offenders since most of them will return to society. Therefore, the goal of treatment is to decrease the chances of reoffending rather than to release an angrier, but wiser, offender who has increased the likelihood of reoffending. The RP treatment model, which is based on social learning theory and maintenance programs for many addictive behaviors (e.g., substance dependence), is now one of the most widely used treatment modalities for sex offenders. First implemented in the late 1970s at Atascadero State Hospital in California (Laws, 1989), RP focuses on denial, cognitive distortions or thinking errors, anger and resentment, sexual abuse cycles, triggers, and victim empathy.

The most important distinguishing feature from other forms of treatment is relapse prevention's emphasis on self-management (Marlatt & George, 1990). This treatment modality posits that the treated individual is not responsible for the etiology of the problem but is responsible for the solution of the problem (Brickman et al., 1982). It has been estimated that 64% of the sex offender

treatment programs in the United States utilize RP as their primary modality (Freeman-Longo, Bird, Stevenson, & Fiske, 1994).

The RP approach assumes that compulsions lead to offenses and that compulsions are maintained and driven by past learning experiences, reinforcement contingencies, biological influences, situational influences, and other factors. According to Pithers and Hills (1999), the goal of RP therapy is to increase the offender's self-awareness and other-awareness by increasing his understanding of empathy, sexuality, feelings, cycles of abuse, and alternative choices regarding his offending behavior. By learning specific coping skills and increasing self-control, the offender has a greater sense of control over his life. RP therapy is usually conducted in prison, and the offender is in as much as 15 hours of therapy per week. Prior to his release, the offender and his therapist develop an RP plan. This step-by-step strategy, which goes beyond a list of "shoulds" and "should nots," helps the offender identify warning signals and triggers, and helps him learn to form a support system that can help keep him accountable as he lives in the community. Eldridge (1997) writes,

> Most offenders initially want to design plans that emphasize all the things they should not do in order to prevent themselves from doing what they want to do-namely offending. However, a lifestyle built around "I shouldn't" is unlikely to be effective for long in sustaining change. A plan based on the development of a positive self-image and the replacement of harmful wants by pleasurably nonabusive wants is much more likely to be successful. The offender who says "I think of the negative consequences every time I want to reoffend, so I should not do

> it" is much more likely to relapse to gratify immediate wants than is the perpetrator who says, "Yes, there are times I'm still attracted to children, but reoffending doesn't fit with the life I want for myself now." (p. 14)

Because RP is built on the belief that effective treatment occurs when the inmate is open and honest, he must be willing to admit to his crime. As stated in a recent article in the Correctional Mental Health Report ("Psychopathy Exclusion," 2000),

> It is by now an article of faith that sex offender treatment will not work with a "denier." Clinicians will require an offender to admit the details of the present offense and, in addition, often insist that the offender admit to other offenses, which may not even be known to the authorities. (p. 39)

This requirement has been challenged and upheld in court. The available leverage and the propensity of offenders to withhold information from their therapists create a unique relationship in therapy and a challenge for therapists to avoid the extremes of being too confrontational and too lenient.

The treatment of offenders continues to be a controversial topic. In the past, literature regarding treatments for sex offenders has been more theoretical than empirical. The treatment of sex offenders has included sterilization, castration, psychopharmacological treatment, civil commitments, and psychotherapies of various orientations. In the last 15 years, however, treatment programs have evolved and have resulted in a proliferation of articles. More laws have been enacted as well. The "Sexually Violent Predator" laws, for example, are commonly known as "Megan's Laws," named after a young girl in New Jersey who was murdered by a sex offender after his release from prison.

These laws, which are similar to the "Sexual Psychopath" laws of the 1930s, are being upheld by the U.S. Supreme Court. They have gained in popularity because they facilitate the lifelong, civil commitment of sex offenders to state psychiatric institutions following their terms of incarceration (Supreme Court, 2001). This paper will examine the research relevant to the RP treatment of sex offenders.

## Assessment of Offenders

A wide variety of beliefs persists about what causes someone to be a sex offender as exemplified in the following excerpt:

> The child molester [is imagined] to be a stranger, an old man, insane or retarded, alcohol and drug addicted, sexually frustrated and impotent or sexually jaded, and looking for new "kicks." He is "gay" and recruiting little boys into homosexuality or he is "straight" and responding to the advances of a sexually provocative little girl.... He is sometimes regarded as a brutal sex fiend or shy, passive, sexually inexperienced person. He is oversexed or undersexed,...a product of a sexually permissive society that encourages sexual acitivity through the availability of pornography, prostitution, drugs, alcohol, and sex outside of marriage. Some say it is a lower-class mentality, poverty, morality.... (Groth, 1978, pp. 3-4)

These ideas have been the impetus for research in the assessment of sex offenders, which has provided the information needed for treatment of these men.

Assessment of sex offenders is important for three reasons. First, a thorough assessment is essential for the development of individualized treatment plans. Second, assessment helps prioritize those waiting for treatment. Finally, it is a screening process that eliminates those who may have a comorbid Axis I diagnosis as well as those who have shown an increase in reoffense rates following treatment ("Psychopathy Exclusion," 2000; Seto & Barbaree, 1999).

As a critical component of therapy, assessment is conducted both initially and as part of an ongoing process throughout treatment. An understanding of the needs of these men is essential for the development of an individualized treatment plan. A cookie-cutter approach may elicit resentment in offenders as well as lead to therapist burn-out.

The Polygraph

A controversial but effective assessment tool is the polygraph (Ahlmeyer, Heil, McKee, & English, 2000), which is used quite extensively in the Colorado State Sex Offender Treatment Program (U.S. Department of Justice, 2001). Before entering the treatment phase, participants in this program are evaluated with the polygraph and must accurately answer questions pertaining to current and past offenses, as well as questions regarding arousal patterns. The polygraph is used at irregular intervals throughout treatment and without forewarning. Its use is often continued as part of the offenders' intensive supervision following their release into to the community.

In examining the prevalence of crossover behaviors (i.e., offenses in more than one legal category), use of the polygraph has yielded the following results: 71% of offenders admitted to offending both children and adults (vs. 6%

admission prior to the polygraph), 51% admitted to offending both male and female victims (vs. 8% before polygraph), and 86% admitted to offending multiple-relationship victims (vs. 20% prior to polygraph). Use of the polygraph has revealed that 50% of known rapists had child victims, 82% of known molesters admitted offending adult victims, and 62% of offenders who were known only to assault nonrelatives admitted having sexually assaulted relatives as well. Only 1 to 3% of offenses are reported in the official records. Furthermore, the majority of sex offenders engage in more than one type of deviant sexual behavior, most started offending during their teen years, and most had been committing offenses for years before they were arrested.

The Interview

Rollnick and Miller (1995) believe that interviewing style is a very important component of the assessment. Motivational interviewing is a directive, client-centered counseling style designed to elicit change by helping clients explore and resolve their ambivalence. The use of directive, client-centered interviewing started in the context of other addictions and relies on a strong therapeutic relationship, a sense of compassion for the client, and a straightforward, "no-nonsense" approach. Assuming the offender has reasons to deceive and withhold information, the interviewer can, nevertheless, respect and encourage him. The interviewer openly acknowledges that although not all the information has been divulged, he believes that it will be in time. This message is conveyed without arguing, demeaning, taking an authoritarian position, or being coercive or punishing.

Assessment begins with a thorough clinical interview that gathers information regarding family background such as sibship position, parental relationship, family drug and alcohol exposure, parental attitudes toward sex, and family power structure. Educational, social (pre-adolescence, adolescence, post-adolescence), sexual (e.g., pre-pubescence, puberty, first experiences, deviant and nondeviant experiences, fantasies during masturbation, unreported sexual offenses), legal (alleged violations, convictions), and emotional background are also crucial. This lengthy interview must be corroborated by collateral interviews and information from other sources (e.g., school, family, police reports, presentence investigation, medical records, employers). The offender is also questioned about the current offense, antecedent events and planning, victim characteristics (most likely to be consistent with reported fantasy pattern), and the nature and duration of the offense. The interviewer would also be interested in prior reported and unreported offenses (Rollnick & Miller, 1995).

Findings of the interview and record review are then combined with psychological testing results that reveal cognitive processes, pathology, and the extent of psychological defense mechanisms (denial, in particular) the offender is utilizing. Examining the capacity for empathy, social and behavioral skills, and religious beliefs and defenses adds to the offender's sexual profile which also includes the offender's victim preference (e.g., sex, age, body type, personality traits) and arousal pattern.

Psychological Tests

An extensive psychological battery of tests is a major part of the assessment process. Measures of sexual behaviors, preferences, and experiences commonly include the Multiphasic Sex Inventory, the Sexual Experiences Survey, the Clarke Sexual History Questionnaire, the Multidimensional Assessment of Sex and Aggression, and the Attraction to Sexual Aggression Scale. Typical measures of cognition regarding sexual beliefs are the Burt Rape Myth Acceptance Scale, the Hostility Toward Women Scale, and the Attitudes Toward Women Scale. Measures of empathy often include the Interpersonal Reactivity Scale and the Rape Empathy Scale. Other measures that assess intimacy levels, anger, personality, and depression may also be useful.

Physiological Tests

Assessment tools such as the Penile Pletheismograph and the Penile Circumference Meter are essential for assessing physiological arousal levels to various stimuli. These tools are unique because an offender cannot easily alter his arousal patterns, and often these tools offer the most valid and reliable information.

The Abel Screen for Sexual Interest is a computerized slide show. The assessee is instructed to view every picture as a sexual partner, rate the picture in terms of level of arousal, and proceed to the next picture. Examples of pictures are those of young children and adults in various stages of dress (without nudity), of people who are tied up, of people holding a whip, of people looking through a window, and of people who appear to be exposing themselves. The Abel Screen calculates the comparative time spent looking at

each picture category, (e.g., young men, women, sadistic or masochistic scenarios) to determine the type of stimuli that produces sexual arousal.

Actuarial Assessment

The concept of actuarial instruments has been researched and explored extensively and has led to the development of tools such as the Minnesota Sexual Offender Screening Tool (MnSOST; U.S. Department of Justice, 2001) which has a validity of .43 in predicting recidivism. Actuarial assessment instruments that utilize static historical factors are also useful in determining the priority of treatment (e.g., MnSOST, Static-99) and in screening for psychopaths who have been negatively impacted by treatment (e.g., Hare Psychopathy Checklist, Violence Risk Assessment Guide).

Schwartz (1998) identified a number of risk factors that are highly correlated with recidivism. One caution is that these measures are more accurately predictive at higher and lower ends of the scales. Individuals who score extremely high are very likely to reoffend, whereas those who have an extremely low score have a relatively small chance of reoffending. Average scores (plus or minus one standard deviation in the bell curve) have less predictive validity. Although these scores indicate that 12 out of 100 offenders with similar profiles have reoffended, these tests are not very useful in predicting which 12 will be the ones to relapse.

Schwartz (1998) listed the following most common static factors used in actuarial tools: the number of sex-related convictions, number of felony convictions, other sex-related arrests without convictions, age at first conviction, use of threat with weapon, number of victims, age of victims, use of force,

length of offending history, alcohol/drug use, prior treatment, number of significant/marital relationships, pattern of employment history, early school history, presence of multiple paraphilias, release environment, age of release, disciplinary history while incarcerated, chemical dependency treatment while incarcerated, vulnerability of victims, position of trust by nonfamilial victim, continued sexual acting out while incarcerated, and supervision requirements upon discharge. Although this is a common list of static variables, there is little agreement between treatment providers. Potential differences between offender types and recidivism factors continue to plague professionals who are evaluating risk and potential for civil commitment. Since the assessment procedure has impact on the future of the offender, reliable and valid instruments are of utmost importance. Schwartz appropriately warns,

> In developing risk assessment scales for involuntary commitment, the researchers involved must constantly keep in mind that they are dealing with depriving a person of their liberty for quite possibly the rest of their life. This entire process grew out of a political situation, (separated from clinicians and research), and remains fraught with political connotations. Every effort should be made to avoid false positives. (p. 7)

## Effectiveness of Current Psychotherapeutic Treatments

A number of researchers have explored the efficacy of sex offender treatment programs. Some studies included only those individuals who had undergone treatment, whereas others included data regarding those who had received no treatment or who had committed nonsexual offenses as controls.

The findings, as well as the strengths and weaknesses, of each study are explicated here.

Furby, Weinrott, and Blackshaw

Furby, Weinrott, and Blackshaw (1989) conducted a landmark study that has been one of the most frequently cited and debated. The authors undertook a comprehensive review of 42 empirical studies on treatment and recidivism of sex offenders. Though they warned that every study contained serious methodological flaws, they state the following conclusion:

> Nevertheless, we can at least say with confidence that there is no evidence that treatment effectively reduces sex offender recidivism. Treatment models have been evolving constantly, and many of those evaluated in the studies reviewed here are now considered obsolete. Thus there is always hope that more current treatment programs are more effective. That remains an empirical question. (p. 25)

Furby et al. (1989) selected studies that contained demographic information on the offender, criminal history, type of sexual paraphilia or disorder, victim characteristics, and amenability to treatment. Each used official police records as part of recidivism review. Studies that relied only on offender self-report were excluded. Studies that were included were conducted with subjects from California, Florida, Utah, Connecticut, Texas, Oregon, Massachusetts, Washington, Wisconsin, Pennsylvania, New Jersey, Illinois, England, Wales, Denmark, and Canada. Sample sizes ranged from 19 pedophiles that received "some behavior therapy" in Connecticut to 3,423 offenders who had received no formal treatment and were released from

Pennsylvania prisons between 1947 and 1962 following a least a 2-year sentence. The length of follow-up in the studies ranged from 3 months to 25 years following conviction (years after release were not given).

Furby et al. (1989) defined recidivism as "a continuation of former patterns of behavior" as applied to sexual offenses and other acts of violence (p. 7). The operational definition of recidivism, however, varied in the studies they evaluated. For example, some operational definitions of recidivism were as follows: reconviction for any offense in the first 3 years following release from prison, return to prison because of parole violation or a new offense within 22 years following release, and a conviction for a new sexual offense within 8 years following release. Recidivism rates in the original studies ranged from 3.7 % (committed new sexual offense, M = 17 months;) to 63.2% (violent sexual assaulters committing any new offense, M = 10 years), depending on the definition for recidivism and the length of follow-up.

In evaluating treatment effectiveness, Furby et al. (1989) found it historically difficult to use random assignment for programs that offer treatment because these programs are obligated ethically to provide that treatment to this group of men since consequences of new offenses are extreme. The results of their study revealed enormous variability in sampling techniques, inadequate and varied operational definitions of recidivism, and significant variability in length of the follow-up period. Furthermore, the studies lacked adequate descriptions of interventions that could help determine the equality of the dependent variables. Consequently, Furby et al. did not attempt to draw any conclusions.

The Furby et al. (1989) study failed to provide much evidence for the effectiveness of treatment programs for several reasons. First, as the authors indicate, many of the treatment programs were no longer in existence at the time of their review because these programs had already failed to demonstrate sufficient effectiveness in the treatment of sex offenders. Among the terminated treatment programs were those at Metropolitan and Atascadero state hospitals (California), the Massachusetts Treatment Center, Western State Hospital (Washington), and the Sex Crime Facility (Wisconsin). In fact, more than 57% of the subjects included in Furby et al.'s study had been treated in then-defunct programs. Only 15 of the 62 studies they reviewed were published after 1978.

Second, 80% of the reviewed studies had been conducted in the U.S. However, only one control group was from the U.S., and 10 nontreated or control group recidivism studies had been conducted in Europe, Canada, and Australia. In addition to the potential selection bias, of the 80% treatment effectiveness studies from the U.S., a number of the studies used the same data. This duplication of data (60% of treated offenders in the U.S.) from defunct, ineffective programs most likely negatively skewed their results regarding the potential effectiveness of more current programs (Furby et al., 1989).

Finally, Furby et al. (1989) examined sex offenders as a congruent population, thereby ignoring possible within group differences. Violent rapists were considered in the same light as were incestuous fathers and fixated pedophiles, disregarding what seem to be obvious differences among these groups. Despite these criticisms, however, this was a seminal study that inspired

researchers to conduct more scientifically sound studies in the area of sex offender treatment.

Rice, Harris, and Quinsy

Rice, Harris, and Quinsy (1989), working at the Penetanguishene Treatment Center in Ontario, conducted a number a studies evaluating their program. In their sample of 50 child molesters, treatment was generally ineffective, with less than 50% of offenders reaching the stated goal for treatment of no arousal to deviant stimuli as measured by a penile circumference meter. They concluded,

> Our data suggests that, although it is politically unpopular to say so, we are, in fact, a long way from being able to agree that treatment is effective at all, let alone that it saves either money or human suffering. (p. 4)

Their treatment modules were offered institution wide and not limited to sex offenders. Though their approach was somewhat RP oriented, it was not specifically designed for sex offenders.

Rice et al. (1989) chose men who were convicted of extraordinarily violent sexual assaults against children. Some of their participants had been found guilty but mentally incompetent or had been declared legally insane. Furthermore, all were returned to a maximum security psychiatric hospital. Recent research has indicated that the treatment of psychopaths is contraindicated (U.S. Department of Justice, 2001), and that psychiatric disorders should be addressed prior to the beginning of sex offender treatment. The predominant pathology of the particular sample selected by Rice et al. would inherently skew the outcome data in the negative direction. Furthermore,

the sample was not provided follow-up training for RP after being returned to the psychiatric hospital, nor was follow-up care provided for these men after they returned to the community.

Marques, Day, Nelson, and West

Marques, Day, Nelson, and West (1993) published preliminary results (i.e., 50 % completed in 7 years) of a 15-year longitudinal study, the Sexual Offender Treatment and Evaluation Program (SOTEP). All participants were from the California Department of Corrections and were incarcerated for rape or sexual assault of a child. Incestuous offenders and concert offenders (i.e., gang rapists) were excluded from the sample. All participants were within 18 to 30 months of release, were between the ages of 18 and 60 years, had two or fewer prior felony convictions, admitted to committing the offense, had no outstanding warrants, spoke English as their primary language, had no Axis I diagnoses that involved psychosis or organicity, and had not had severe behavior problems in prison.

Offenders were divided into three groups. The treatment group consisted of offenders who volunteered for treatment and were randomly selected to participate in it. The volunteer control group consisted of offenders who volunteered for treatment, but did not receive it. This group was matched with the treatment group for age, type of offense, and criminal history. The third group was a non-volunteer group, subjects who qualified for the treatment group, but chose not to participate. SOTEP provided the treatment group 18 to 30 months of cognitive behavioral treatment based on the RP model of therapy (Marques et al., 1993).

Volunteers from a pool of 15,000 sex offenders in California were randomly matched and assigned to treatment and nontreatment groups. At the 7-year mark, 602 offenders had been released. Of those released, 229 eligible prisoners volunteered for treatment, and 373 did not. Twenty-six withdrew prior to the start of treatment, 13 withdrew after treatment began, and 7 terminated involuntarily due to severe behavior problems. Eighty-six volunteers had been randomly assigned to treatment and 97 to the control group. The mean time at-risk (i.e., living in the community) was 34.2 months (range = 3.2-78.4 months). Follow-up consisted of annual interviews and reviews of recent criminal backgrounds. Recidivism was defined as any re-arrest for sexual or nonsexual violent offenses. Because the importance and impact of sex offender treatment could be masked if all offenses were examined together, these two categories were analyzed separately and resulted in occasional overlap that placed some offenders in both recidivated categories (Marques et al., 1993).

Over all, preliminary data suggests that younger subjects are more likely to commit a new sex offense and other violent offenses ($p < .001$). Subjects with prior felony convictions were at an increased risk for new sex offenses ($p < .05$). The risk of committing a new sex offense was marginally higher for those whose offense type was molesting boys or children of both sexes ($p < .06$). Rapists and molesters of female victims were at a greater risk for committing a new violent offense versus a new sexual offense ($p < .001$), and there seemed to be no noticeable interaction effect (Marques et al., 1993).

Using the survival analysis method, the estimate for new sex offenses and new nonsexual offenses was lower for treated offenders than for the control

volunteer group, but the difference was not statistically significant, ($p < .05$). Treatment subjects did show a significantly lower risk for new sex offenses ($p < .05$) than did nonvolunteers. Treatment subjects also demonstrated a lower risk for committing new violent offenses than control group subjects did, but the difference did not reach statistical significance (Marques et al., 1993).

Concerning the specific impact of RP treatment, significant results should be solidified after completion of this 15-year study. In regard to violent offenses, this data has demonstrated a 14.3 % recidivism rate for treated subjects (i.e., after 1 year or more of treatment), a 62.5% recidivism rate of extreatment subjects (i.e., started treatment but left before 1 year), a 24.7% recidivism rate for volunteer controls, and a 19.8% recidivism rate for nonvolunteer controls. Specifically exploring new sex offenses by type, data revealed a treatment group reoffense rate of 8.2%, which is quite promising but does not stand out in comparison to control groups. Nevertheless, the difference between the rapist recidivism rate of 9.1% and the control group rate of 27.8% is significant (Marques et al., 1993).

In 1985, Marques et al. (1993) began a very progressive study. Though they used random assignment with their volunteers, a greater percentage of the treatment group was single and had prior incarcerations as disordered offenders. When these higher risk factors are statistically controlled, a significant treatment effect would be expected. These researchers have used adequately powerful statistical analysis techniques and have taken numerous possible factors into account. Once they have completed this project, the utilization of a factor analysis to explore the variables would be helpful.

Barbaree, Seto, and Maric

Barbaree, Seto, and Maric (1995) reported results from a sex-offender treatment program that began in 1989 at the Warkworth Sexual Behavior Clinic in Ontario, Canada. This facility treats approximately 75 sex offenders each year in cognitive behavioral (RP) group therapy. This study examined the first 250 sex offenders who had participated in this program. One hundred twenty-three were rapists, 15 were sex-killers, 56 were incest offenders, and 56 were extra-familial child molesters. There were no significant educational, SES, or work differences between group types, but rapists and sex-killers tended to be significantly younger than other offender types. Assessment included administration of the Rape Myth Acceptance Scale, which failed to discriminate adequately between pre- and post-test administration. The Multiphasic Sex Inventory offered the most useful information and was the least threatening to the participants.

Of the 250 participants, 77.2% completed treatment, and no historical factors emerged as predictive of treatment completion. More than 300 variables were categorized into 10 historical factors: childhood behavior problems, erratic employment, previous treatment, quality of early life, separation from family of origin, sexual promiscuity, alcohol problems, severity of index offense, antisocial history, and criminal behavior. Twenty-three and one-half percent of the pretreatment risk was explained by antisocial history and criminal history, whereas 68.1% of post-treatment risk score variance was attributed to the pretreatment risk score, treatment behavior, treatment change, and clinical impression. A third regression analysis found no correlation between written

test factors and prediction of treatment completion or recidivism risk (Barbaree et al., 1995).

Barbaree et al. (1995) included data for 215 of the 250 offenders. Of these men, 198 were eligible for release, 1 died during treatment, 12 were serving life sentences, and 4 had been designated as dangerous offenders. Of the 198 eligible offenders, 132 had been conditionally released to the community: 23 on day parole, 15 on full parole, and 94 by their statutory release date. The average time at-risk was 43 months (range = 1 week to 5.2 years). Survival analysis was used in follow-up assessment of the treated offenders. After 1 year, 29.1% of the rapists and 14.4% of the molesters had failed. After 2 years, 47.7% of the rapists and 28.2% of the molesters had failed. After 3 years, 62.9% of the rapists and 43.0% and of the molesters had failed.

However, failure did not mean that the offenders committed a new sexual offense. At the time of this study, only a small number of offenders had passed the 3-year mark in their supervision, making the significance of these findings less powerful. During the average 2.5-year follow-up, 17 serious offenses had been committed by participants, revealing a serious offense recidivism rate of 8.4% and a sexual recidivism rate of 6.4%. Of the 132 men who had been released, 42 failed their conditional release for one of the following reasons: relapse for which no official action was taken, suspension for breech of RP plan, or revocation of the conditional release. Rapists were more likely to fail the conditional release than were molesters (40.7% vs. 25.0%), though these percentages are not statistically significant due to the low number of subjects in this group. Barbaree et al. (1995) concluded that the treatment process itself is a

factor in the prediction of outcome, that treatment responsivity is as important as the treatment itself, and that treatment does reduce the number of failed conditional releases and the number of serious new offenses.

Barbaree et al. (1995) offer support for the positive results of cognitive behavioral RP therapy in the treatment of sex offenders. Their study loses power since it was a retrospective study without control groups and simple statistical methods (chi square) were used.

Mander, Atrops, Barnes, and Munafo

Mander, Atrops, Barnes, and Munafo (1996) conducted a recidivism study with participants and nonparticipants in their sex offender treatment program between 1987 and 1995. They analyzed participant characteristics, treatment variables, reason for discharge, and stage of therapy at discharge. Subjects had received treatment at Hiland Mountain Sex Offender Treatment Program and may have also had other treatment while incarcerated such as that provided for drug abuse, anger management, or mental illness. The researchers utilized a four-phase model of RP therapy. Their pretreatment stage provided assessment, orientation, education, clinical management, and a challenge to offense denial. The second stage of beginning treatment prepared offenders to give and receive feedback, to utilize self-regulation and social skills, and to assume responsibility for their instant offense, victim empathy, and precursors to offending. Intermediate treatment was the third stage and focused on risk factors and the internalization of skills acquired in previous phases. The last stage, advanced treatment in preparation for eventual discharge, focused on the mastery of knowing one's offense cycle and the application of knowledge to all

areas of life. Each stage lasted from a minimum of 6 months to as long as 12 months, with the exception of the shorter pretreatment phase.

Mander et al. (1996) divided the subjects into one treatment group and three control groups. The treatment group consisted of 411 men who had participated in at least a modicum of treatment between 1987 and 1995. A motivated control group included 74 male sex offenders who desired treatment but whose sentences were too short to accommodate such an investment. An unmotivated control group consisted of 100 randomly selected male sex offenders who had refused treatment, and a non-sex-offender control group consisted of 100 randomly selected male non-sex offenders. Of the 411 men in the treatment group, 259 (63%) had been convicted of crimes against children, 135 (32.8%) had been convicted of sexual assault, and 17 (4.1%) had been convicted of other offenses.

For the purpose of this study, Mander et al. (1996) defined recidivism as any re-arrest. Recidivism was divided into the following six categories for statistical analysis: first arrest for any offense, most serious arrest for any offense, first arrest for non-sex offense, most serious arrest for a non-sex offense, first arrest for a sex offense, and most serious arrest for a sex offense. The researchers also examined length of treatment, stage of treatment, and reason for discharge as possible factors for analysis of the treatment group. They utilized a procedural analysis, which they termed survival analysis, that considers differences in length of time that offenders remain in the community without being arrested for a new offense. This methodology takes into account the fact that the longer an offender remains in the community, the more

opportunity he has to recidivate. The success of treatment was therefore measured by the length of time the offender remained in the community without reoffending. The researchers concluded that treatment can and does succeed in decreasing the number of re-offenses and the length of time that elapses prior to the offender's arrest for another crime. They also noted serendipitously that Alaskan native men dropped out of treatment at a higher rate than non-native men and that they benefited from treatment less. They also noted that severe substance abuse was correlated with early discharge from treatment.

The average length of treatment was 17 months. More than half (58.4%) of the treatment participants were discharged during or just after completion of the beginning stage of treatment and, therefore, did not complete the intermediate or advanced portions of treatment. One hundred forty-one men left against therapist advice, 105 were removed or dismissed due to behavioral issues, 125 completed the program, and 40 were discharged early due to a completed sentence. Offenders were also divided into three age categories (under 30 years, 30-49 years, and over 49 years). Mander et al. (1996) reported no new sexual offenses by those who had completed treatment and had been recommended for discharge. Interestingly, the unmotivated sex offender group did slightly better than the motivated sex offender group (though not statistically significant at $p = .01$) in almost all areas.

Mander et al. (1996) provided neither the average nor range of time periods that offenders were back in the community. Though they included a number of charts, their factor analysis was not sufficiently stringent. They stated

that 54% of the treatment group did not complete the second and third stages of treatment, but offered no analysis of the stage completion in relation to offenses. The authors admit that they did not take into account concurrent treatment for other problems, a confounding variable in examining treatment effectiveness of RP therapy which often overlaps with substance abuse counseling. The differences between control groups and an analysis of within-treatment variables (i.e., length of treatment participation, completers vs. noncompleters) were also omitted from the statistics. Since recidivism rates differed to an unknown degree among types of offenders, between group differences could also be of significant import. Sexual reoffenses are typically underreported, and this lack of full information may, therefore, have provided deceptive statistical results. Nonetheless, this study may stimulate further research by demonstrating a degree of effectiveness of treatment.

Olsen and Aytes

In an unpublished report to the Oregon Department of Corrections (Olsen & Aytes, 1997), Jackson County Community Corrections explicated an intensive supervision program in 1981. In 1995, outcome data collection was begun to assess the effectiveness of this program. The treatment group consisted of 327 sex-offenders who were receiving treatment and intensive parole supervision. One control group consisted of 89 sex offenders who received no treatment in neighboring Linn county (10 who had received treatment were excluded), and a second control group consisted of 231 non-sex-offenders from Jackson County. The research examined factors related to age, gender, dates of

entering and leaving supervision, treatment completion status, and dates and nature of subsequent misdemeanors and felonies.

A chi square analysis indicated a significant difference between the treated and untreated group. The Jackson County Offenders who completed treatment had a 6.5% recidivism rate versus the Linn County control group who had a 16.9% recidivism rate. This analysis did not control for the amount of time under supervision, which may have been a significant factor since some offenders had spent more than 8 years under supervision and others had less than 2 years of supervision. When controlled for time using a Kaplan-Meyer survival analysis, the differences were less. At the 3 year follow-up, the difference was a 7.1% recidivism rate for the Jackson county treated offenders versus 9.6% for the Linn County control group. At the 5-year follow-up, the difference was 12.4% versus 15.0%. However, when treatment was 1 year or more, the difference was slightly more powerful at the 5-year mark: 8.8% versus 15.0% recidivism for treated versus control groups. The 5-year percentages included convictions for new offenses. All analyses showed a lower recidivism rate for sex offenders (treated and untreated) when compared to non-sex offenders (Olsen & Aytes, 1997).

Though they utilized control groups, Olsen and Aytes (1997) failed to use random selection, which leaves the question of the effectiveness of treatment unanswered. Though a difference in recidivism rates was apparent, the difference cannot automatically be attributed to treatment rather than to self-selection into the program or other unknown factors. The researchers did not conduct a factor analysis of demographic data to assess for differences in age,

years in prison, number of previous convictions for sexual offenses, victim typology, and type of sexual offense.

Kennedy and Hume

Kennedy and Hume (1998) conducted a retrospective study in Florida with 114 treated adolescent sex offenders over a period of 1 to 6 years following release. Treatment was defined as completion of a 12-month RP program that utilized standard group relapse prevention, education, and individual therapy. Offenders were required to admit their offenses and ask for treatment in order to be admitted into the program. Once an individual was admitted, he completed a 3-month orientation phase, an 8-month treatment phase, and a 4-week discharge-readiness phase. Of the participants in this study, 1 had been out of prison for 6 years; 19 had been out of prison for 5 years; 19 had been out of prison for 4 years; 25 had been out of prison for 3 years; 24 had been out of prison for 2 years; and 26 had been out of prison for 1 year. Twenty-two had committed a non-sex crime following their release, and 5 had committed a sex crime. Defining success as the absence of any arrest for a sexual offense, Kennedy and Hume claimed a 96% success rate for this program and stated that failure to complete their program leads to "almost a 100% failure rate" (p. 2).

As with much of the research in this field, Kennedy and Hume's (1998) retrospective study lacked control or comparison groups. Since no statistical analysis was conducted, the purported success rate of this program cannot be attributed to any specific factor or factors. They did not discuss those who failed to complete treatment, the possibility of new sexual offenses that were not reported or successfully prosecuted, and the short time (12 months) since the

release of almost 25% of their subjects. They did not state when the 5 new convictions occurred—whether in the first year or the sixth, and it is unclear how they arrived at the near 100% failure rate for noncompletion of their program. In addition to a lack of significant follow-up time, their research methods lack appropriate controls, between-group comparisons, and significant analyses of the data.

Hanson and Bussiere

Hanson and Bussiere (1998) conducted a meta-analysis of 61 follow-up studies (N = 23,393). Inclusion criteria demanded the following conditions for each study: (a) included a follow-up period (no minimum time requirement), (b) reported recidivism information on sexual offenses, (c) reported recidivism information on any reoffense, and (d) included sufficient statistical information to calculate the relationship between a relevant offender characteristic and recidivism. The studies represented research from the U.S. (30), Canada (16), the United Kingdom (10), Australia (2), Denmark (2), and Norway (1). Fifty-five studies examined mixed groups of offenders, and six studies examined only child molesters. The studies included both correctional settings and community placements of the sample population.

Recidivism was most commonly defined as reconviction (84%), arrest (54%), self-reports (25%), and parole violations (16%). Each study was rated on a weighted scale that ranged from 1 to 7. A score of 1 represented a study with questionable methods (e.g., self-report only) and inadequate follow-up time (i.e., less than 6 months). A score of 7 represented a study with multiple, credible data sources (e.g., local records, national records, collateral sources) and long

follow-up periods (i.e., longer than 10 years). The researchers examined 56 static factors and their correlation with recidivism rates. Adequacy ratings ranged from 3 to 7 (M = 4.6, SD = 1.0). The three categories of recidivism were as follows: sexual recidivism (self-report or conviction for new offense), non-sexual recidivism (any arrest for a non-sex offense), and general recidivism (any type of reoffense; Hanson & Bussiere, 1998).

Findings revealed a sex offense recidivism rate of 13.4% for the entire sample (N = 23,393), 18.9% for rapists (n = 1,839), and 12.7% for child molesters (n = 9,603), in an average follow-up period of 4.5 years. When recidivism was defined as any reoffense, there was a 36.3% rate for the entire sample (N = 19,374), 36.9% for child molesters (n = 3,363), and 46.2% for rapists (n = 4,017). Sexual interest in children as measured by phallometric assessment was the strongest predictor of relapse (r = .32). Though the Hanson and Bussiere (1998) drew no conclusions regarding the effectiveness of treatment, they identified failure to complete treatment as a moderate predictor of relapse (r = .17). Other highly correlated static predictors included employment instability (r = .39), prior sex offense (r = .29), stranger victim (r = .38), force or injury to victim (r = .25), and severe psychological disorder (r = .25).

Hanson and Bussiere (1998) conducted one of the most scientifically sound and informative studies to date. The researchers used complex statistical analyses to better understand a labyrinth of static (historical) predictors. They found contradictory evidence to two popular beliefs: that sexual abuse as a child leads to sexual abusiveness as an adult (r = -.02) and that all offenders eventually commit a new sexual offense (13.4% at 4.5 years post release with or

without treatment, and < 40% at 15 years post release). Hanson and Bussiere have provided a model for future meta-analyses and set the standard for original research studies.

Reddon, Payne, and Starzyk

Reddon, Payne, and Starzyk (1999) examined therapeutic factors important for the group treatment of 100 sex offenders (mean age = 35.0 years; range = 20-54 years) whose time in treatment ranged from 6 to 18 months (M = 10.7 months). Their victims ranged in age from 2 to 32 years (M = 11.6), and 82.6% of the victims had been female. Full Scale IQ scores ranged from 77 to 129 (M = 98.9). The study's participants were rated on the Yalom Card Sort, which requires participants to separate 60 items into 12 factor groups using a forced-choice format. The results were then correlated with length of treatment, age of offender, age of victim, sex of victim, and offender IQ score. The 12 factor groups were as follows: catharsis, self-understanding, group cohesiveness, interpersonal learning (output), interpersonal learning (input), existential factors, family reenactment, instillation of hope, universality, altruism, guidance, and identification. Their use of Spearman's rank order correlation between rankings resulted in a correlation of .87 ($p < .001$). Ten of the 12 therapeutic factors were ranked equivalently. Instillation of hope ($r = .22$, $p < .05$) was the only therapeutic factor to be correlated significantly with treatment duration.

Reddon et al. (1999) state, "Results indicate that although sex offenders and psychiatric outpatients consider Yalom's (1995) 12 therapeutic factors to be of similar relative importance, sex offenders consider family reenactment to be

more important and interpersonal learning (input) less important" (p. 97). Furthermore, they add,

> Examining sex offender's perceptions of therapeutic factors in group psychotherapy is useful for ascertaining similarities and differences between this population and a more general group of psychiatric patients. More importantly, however, assessing sex offender's perceptions of therapeutic factors may provide therapists with some guidance for addressing the special needs of sex offenders. (p. 99)

The view of these researchers is that family issues stemming from childhood are more important than other factors in the treatment of sex offenders and that creating an accepting and supportive environment is important to facilitate the interpersonal growth and learning of the offender.

All participants in Reddon et al.'s (1999) study came from the same treatment program, the Phoenix Program, thereby limiting demographic variability to a small location in Canada. Furthermore, this program is an intensive inpatient program that requires approximately 35 hours of therapy per week, combining group psychoeducation and more traditional psychotherapy. These factors make it difficult to attribute results to one specific aspect of the program. The forced-choice questionnaire and the fact that it had a 100% completion rate may have impacted the participants responses regarding what is important, especially if their opportunities to visit family and friends and their future freedom depended on program participation and acceptance. Finally, the researchers did not examine success as based on time without the commission of another sexual offense. By omitting this aspect of program

evaluation, this study fails to support the efficacy of therapy factors as it pertains to public safety.

Moore, Bergman, and Knox

Moore, Bergman, and Knox (1999) examined factors related to completion of treatment for sex offenders.

> Successful treatment outcome with sex offenders is usually defined as lower re-offense rates. Based on recidivism rates of treated offenders, research (e.g., Abel, Blanchard, & Becker, 1978; Barlow 1974) suggests that treatment is effective despite the view that the reliability of treatment as a viable means of reducing sexual offenses is questionable. Successful outcomes have been predicted in outpatient sex offender treatment by selectively identifying appropriate clients for such treatment. (p. 74)

The researchers randomly selected 162 offenders' files from the Tennessee prison system. Participants had voluntarily received previous treatment within the prison system. Their files were reviewed and data were collected on completion of program, age, prior offense record, education level, ethnicity, and marital status. Offenders who completed the program had less violent prior offenses, were previously or currently married, had more prior arrests for minor substance related offenses, and had younger victims. Offenders who did not complete the program had more violent criminal histories, were never married, had been diagnosed with antisocial personality disorder, and had older victims.

Moore et al. (1999) used an adequate definition of success for offender therapy, but conducted their research using factors that predicted the completion of therapy, rather than the efficacy of the interventions. Findings

indicate that selection criteria is extremely important for offender participation in therapy. Though inconclusive regarding what makes treatment successful, results infer that an Axis II diagnosis (Antisocial Personality Disorder), the presence of previous violent offenses, and lack of marital history decreases the chance that therapy will be effective for the offender since failure to complete the treatment likely means that it will also be ineffective.

Polizzi, Mackenzie, and Hickman

Polizzi, Mackenzie, and Hickman (1999) reviewed 21 sex offender treatment programs. They defined recidivism as rearrest for any reason, reincarceration, violation of any aspect of community supervision, or a self-reported sexual offense. The researchers used a rigor scale to assess the usefulness of the studies. A score of 1 indicated that a study found a correlation between a treatment program and a measure of crime risk factors, and a score of 5 indicated the study used random assignment and analysis of comparable units to program and comparison groups. Studies scoring 1 were not considered useful and were discarded, and none were given a score of 5. The reviewers excluded 8 of the 21 original studies due to low rigor scores.

Of the remaining 13 studies, 8 were prison-based programs and 5 were non-prison-based programs. Four studies scored 4 on the rigor scale, two scored 3, and seven scored 2. The studies with a score of 2 were not weighed as heavily as the studies with higher scores. The reviewers concluded that there are conflicting viewpoints regarding the efficacy of treatment. Most studies lacked sufficient scientific rigor to be considered valuable in understanding what

makes the treatment program effective or whether treatment actually impacts recidivism rates (Polizzi et al., 1999).

Though Polizzi et al. (1999) state some obvious conclusions, their assertions are drawn from observations and self-ratings, rather than from an analysis of significant outcome variables in these studies. Their study duplicated the Furby et al. (1989) study that was conducted 10 years earlier, and yet they came to fewer conclusions and offer fewer directions for the future.

Nicholaichuk, Gordon, Gu, and Wong

Nicholaichuk, Gordon, Gu, and Wong (2000) published the results of a postdictive study conducted at Correctional Services of Canada's Regional Psychiatric Center (Saskatoon). They compared treated high-risk offenders (e.g., recidivists, those with extensive criminal histories) who had been treated at Clearwater Treatment Center to untreated offenders, matched for year of index offense, age at index offense, and prior criminal history (+/- 2 offenses).

The treated group consisted of 296 sex offenders who had been treated at Clearwater between 1981 and 1996 using cognitive-behavior and RP methods. Fifty-seven percent were rapists, 17% were pedophiles, 15% were offenders against both children and adults, and 11% were child incest offenders. The matched comparison group was drawn from offenders incarcerated in the same region of Canada. Of the original 283 comparison group members, only 80 could be categorized by type of offense due to incomplete records. Of these 80, 62.4% were rapists, 26.3% were pedophiles, 5% were offenders against both children and adults, and 6.3% were incest offenders. The authors noted that some of the

untreated controls could have participated in treatment outside of the Clearwater Treatment Center (Nicholaichuk et al., 2000).

Follow-up continued after the men's initial release (following index offense) until June, 1996. Official criminal records of the men after initial release were reviewed, and the men were placed in three categories: new sexual offense, other new offense, and no new offense. Rate of parole violations and rate of no new admissions to prison were also noted in the criminal record review. Analyses were employed through three strategies. First, tests of proportions were conducted comparing the conviction of a new offense with a sentence of more than 2 years, and a test of proportion was used to examine new offenses. Second, survival analysis was used to evaluate the amount of time after release between treated and untreated sex offenders and provides a credible indication of outcome over extended periods of time. Finally, Nicholaichuk et al. (2000) evaluated the men using a Criminal Career Profile (CPP) to graph each man's violence curve.

An exact pairwise match was achieved with 30% of the men ($n$ = 84). For the remainder of the group, a more relaxed standard (+/- 2 offenses) was utilized. Considering all events (regardless of length of sentence), Nicholaichuk et al. (2000) found that 43 of those treated and 94 of the untreated controls committed new sexual offenses. Ninety-five treated men and 99 untreated men committed nonsexual offenses. One hundred forty-two treated and 80 untreated offenders were not readmitted for any reason. These figures reveal a clear difference between the treatment and control groups in rate of sexual reoffenses committed, as well as the rate of participants remaining free of any offense.

The survival analysis regarding the commission of new sexual offenses indicated a significant difference between the two groups (Wilcoxin (1) = 10.63, p , .001). Control group offenders began reoffending sooner after their release and continued reoffending at higher rates throughout the follow-up period than did the treatment group. The CCP indicated that both groups had a reduction in violence following their release; however, the treated group showed a steeper decline than the control group, revealing a greater reduction in violence and offenses. Paired t tests showed significant differences in sexual regression for rapists and pedophiles, but not for incest offenders. A repeated measure ANOVA was conducted taking pre- and post-treatment slopes of the CCP as dependent measures and revealed a significant treatment main effect, F (1, 570) = 166.47, p <.0001 (Nicholaichuk et al., 2000).

Nicholaichuk et al. (2000) conducted one of the more scientifically sound postdictive studies in the area of sex offender treatment research. Their use of a matched control group was an important component of their study, and their use of survival analysis, CCP, and tests of proportion revealed significant benefits of treatment for all but incest offenders, who already have a typically low rate of reoffense. Their statistical analyses were sufficiently rigorous; however, they might have included a second control group that would have taken into account length of treatment, completion of treatment, drop-out rate, and type of community supervision, all of which could have a significant impact on outcome. That these factors were not considered weakened these positive results.

## Conclusions

Effective treatment for sex offenders requires a comprehensive, multidisciplinary approach that includes thorough assessment, polygraphy, and RP therapy, as well as intensive supervision and maintenance therapy following release from prison. RP is a five-stage process (assessment, pretreatment, treatment, release planning, and intensive parole supervision) that addresses behavior change and behavior control versus cure. Its approach differs from all other therapies in assuming that the offender has no reason to tell the truth and, in fact, will not tell the truth without some confrontation and leverage. Its compassionate confrontational approach relies on motivational interviewing, group peer pressure, and effective supervision to increase the probability of success for the offender upon his return to the community. RP is a comprehensive therapeutic program that teaches specific skills that are to be practiced over a lifetime.

Furby et al.'s (1989) study has been one of the most influential contributions to the field of sex offender therapy. They have concluded that there is no evidence to support the benefits of treatment for sex offenders in general, a belief that has since been echoed by many other researchers (Rice et al., 1989; Polizzi et al., 1999). Furby et al. made the following statement about the ineffectiveness of treatments:

> Eight of the nine studies of untreated offenders (with follow-up periods ranging from six months to 10 years) have relatively low recidivism rates, all below 12%. In contrast, two thirds of treated offender studies have rates higher than 12%. (p. 24)

These researchers failed to focus on the most current treatment programs, emphasized extended periods since release from prison, and assumed similarity of study participants rather than their inherent differences (e.g., those with mental illness, as anyone who has begun treatment regardless of completion). However, these researchers acknowledge the limitations of attempting to extrapolate long-term implications from short-term follow-up. They also recognize that there has been no standard for the concept of relapse, which has been defined in a number of ways ranging from "any parole violation" to "any new conviction for a sexual offense."

Certainly there are a number of studies that have found no significant benefit of treatment in general; however, a growing number of studies have found a significant benefit for RP therapy (Barbaree et al., 1995; Hanson & Bussiere, 1998; Kennedy & Hume, 1998; Mander et al., 1996; Marques et al., 1993; Nicholaichok et al., 2000; Olsen & Aytes, 1997; Reddon et al., 1999). Findings on effectiveness range from a "96 percent success rate for the specific goals of the sex offenders treatment program" (Kennedy & Hume, p.3) to "sex offenders were at an increased risk of recidivism if the terminated treatment early ($\underline{r}$ = .20) or showed low motivation for treatment ($\underline{r}$ = .11)" (Hanson & Bussiere, p. 353). Mander et al. also noted,

> Though for some offenders (abuse of minors) there was not much difference in re-offense rate between those who left after the intermediate phase and those who reached the advanced phase, the further offenders advanced in treatment, the more benefit is derived, with those who completed all phases having no new [sexual offenses]. (p. 78)

The argument that treatment can reduce sexual recidivism is made even more compelling by the fact that all three analytic techniques employed yielded similar results. The tests of proportion, survival analysis, and analysis in changes of the CCP not only point to a reduction of new sexual crimes, but to a reduction in the degree of violence post treatment. These data also provide support for the risk/need principle. The higher the rated need for treatment (with the exclusion of those considered to be psychopaths), the greater the treatment effect. Those with lower treatment needs (incest offenders) had a lower treatment effect (Nicholaichuk et al., 2000).

## Future Directions

Methodological problems exist within all studies to one degree or another. Several issues lead to additional considerations for further research on the effectiveness of RP (as well as other forms of treatment) for sex offenders and its use as a post-incarceration strategy (Cumming & Buell, 1996). Certainly the use of standardized operational definitions, more detailed data bases, extension of follow-up time, and survival analyses would provide greater knowledge about the distinctive aspects of treatment programs. Thus far there has also been little differentiation among types of sex offender outcomes, and data on female offenders has been virtually omitted from the literature. The presence of thought disorders and Axis II diagnoses as well as potential ethnic or cultural differences may also be confounding variables that warrant further exploration.

Not all studies of RP have had equivalent operational definitions of treatment (length, scope, and intensity), follow-up periods (ranging from 2 months-20 years), or definitions for relapse. There has been no definition of recidivism that has been accepted field-wide. Does recidivism consist of post-release commission of any crime, only sexual crimes, or only rearrests for a sexual offense? Can longitudinal studies account for attrition? Will offenders who have disappeared be included in the relapse category, or will they be in another category? Confounding issues such as these futher complicate the process and make this type of assessment a monumental task.

Determining the treatment efficacy for sex offenders is very difficult due to the high number of confounding variables, the number of factors to be analyzed, and problems isolating treatment effects (Barbaree, 1997). As Furby et al. (1989) stated,

> Despite the relatively large number of studies on sex offender recidivism, we know very little about it. Because of the many practical difficulties of designing and conducting studies in this area, methodological shortcomings are present in virtually all studies, making the results from any single study both hard to intepret and inappropriate for the use of conventional confidence levels. (p. 27)

Consequently, many believe that sex offending may be a behavioral disorder that cannot be cured (National Organization on Male Sexual Victimization website, 2001). Though a significant number of articles have been written on RP, most have not been conclusive, rigorous, longitudinal, or included control groups. Though RP focuses on self-management, preliminary results indicate

that it should also incorporate intensive community supervision by a therapeutic team of parole supervisors, therapists, work supervisors, and family members, as well as utilize polygraphy and periodic maintenance therapy for 1 to 6 months (U. S. Department of Justice, 2001).

Most researchers have not taken into account the successes that may be based on an extensive period of time without another sex offense. This may be one of the most important pieces of research yet to be consistently included in ongoing research. Marques et al. (1993) wrote,

> As research effort has progressed over the years, we have come to believe that the greatest obstacle to the development of a consistent, empirical data base regarding sex offender treatment is the size of the task. Although some clinical research can focus on outcomes that develop during or soon after treatment, sex offending (especially as measured by the current state of the art) requires significant follow-up periods to determine if the treatment has adequately inoculated offenders against relapse. This, in turn, requires a considerable investment of time and money if information on treatment outcomes is to be acquired. Considering that the typical duration of federal research grants is five years, it is clear that longitudinal research such as this requires a commitment exceeding that of most behavioral or clinical investigations. (p. 16)

In addition to longer follow-up periods and the use of standardized definitions, future studies need to give thoughtful consideration to the selection

and description of samples in order to appropriately apply findings to specific classes of offenders.

> At this time, existing treatment approaches do not apply equally to all offenders, appearing less effective with rapists than pedophiles.... Because rape is a multidimensionally determined act, a treatment design must be able to address issues such as personal victimization, cognitive distortions, behavioral treatment to alter excessive arousal to sexually abusive fantasies, victim empathy, emotional recognition and modulation, and attributional processes. ( Pithers, 1993, p.181)

Furthmore, a standardized description for specific offender classifications is needed, and certain demographic variables may also factor into the process of analysis. A number of actuarial tools (e.g., MnSOST, Static-99) examine both static (nonchangeable) and dynamic (fluid) factors, but to date they have not played a large role in the evaluation of treatment effectiveness. The use of criminal records, which have held a primary role, may need to be eliminated from analysis since most sexual offenses go unreported and few are successfully prosecuted. Instead, more weight may be appropriately placed on polygraphy data in determining the extent and characteristics of an offender's behaviors.

The relationship between Axis II personality disorders and sexual offenses is an important component of recidivism studies that seek greater understanding of treatment needs and effectiveness. The utilization of assessment tools such as the Abel Screen for Sexual Preference and the Multiphasic Sex Inventory may provide better data about the offender and how pathology may be related to treatment effectiveness. Victim characteristics (e.g.,

strangers or familiar persons, prepubescent or pubescent, male or female, intrafamilial or extra-familial) may also be important variables that affect treatment needs and outcomes.

A more recently implemented component of treatment, intensive supervision, is generally considered to be effective. However, no research has been done to support it, so whether or not supervision impacts offenders who have returned to society remains unknown. Furthermore, it may not be economically feasible to provide a polygraph every 6 months for every sex offender, especially if such treatment were to be mandated for life. These practical issues need to be addressed in the future development of effective sex offender treatment.

To date, most studies have been retrospective (Furby et al., 1989) and included relatively small samples. Though single-group, post-test only designs have been useful and have stimulated research designs for prospective studies, more prospective studies with control groups, random assignments, and longitudinal follow-up are needed.

A few additional issues may be important in the future of research and development of sex offender treatment. First, there needs to be further study in the areas of special-needs groups such as those with mental retardation, major Axis I mental illnesses, psychopaths, and women. Second, there needs to be further research to dilineate the specific components of the current RP model of therapy and the degree of their effectiveness. Third, further exploration of minority issues in offender treatment is needed. Finally, the societal trend in support of the Sexually Violent Predator Laws that allow for the offender's

further incarceration at a psychiatric hospital (in the absence of an Axis I diagnosis) for as long as "life" emphasizes the need for research to help define effective treatment for the men who commit sexual offenses.

REFERENCES


Abel, G. C., Mittleman, M. S., Becker, J. V., Rather, J., & Rouleau, J. (1988). Predicting child molesters' reponse to treatment. Annals of the New York Academy of Sciences, 528, 223-234.

Ahlmeyer, S., Heil, P., McKee, B., & English, K. (2000). The impact of polygraphy on admissions of victims and offenses in adult sexual offenders. Sexual Abuse: A Journal of Research and Treatment, 12, 123-138.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

American Psychiatric Association. (1999). Dangerous sex offenders: A task force report. Washington, DC: Author.

Barbaree, H. (1997). Evaluating treatment efficacy with sexual offenders: The insensitivity of recidivism studies to treatment effects. Sexual Abuse: A Journal of Research and Treatment, 9, 111-128.

Barbaree, H. E., Seto, M. C., & Maric, A. (1995). Sex offender characteristics, response to treatment, and correctional release decisions at the Warkworth Sexual Behaviour Clinic. Report to the Solicitor General of Canada.

Barnard, G.W., Fuller, A. K., Robbins, L., & Shaw, T. (1989). The child molester: An integrated approach to evaluation and treatment. New York: Brunner/Mazel.

Brickman, P., Rabinowitz, V. C., Karuza, J., Coates, D., Cohn, E., & Kidder, L. (1982). Models of helping and coping. American Psychologist, 41, 368-384.

Carnes, P. (1992). Don't call it love. New York: Bantam Books.

Cumming, G. E., & Buell, M. M. (1996). Relapse prevention as a supervision strategy for sex offenders. Sexual Abuse: A Journal of Research and Treatment, 8, 231-241.

Donato, R., & Shanahan, M. (1999). The economics of implementing intensive in-prison sex-offender treatment programs. Trends and Issues in Crime and Criminal Justice, 134, 1-6.

Dougher, M. J. (1995). Behavioral techniques to alter arousal. In B. K. Schwartz & H. R. Cellini (Eds.), The sex offender: Corrections, treatment and legal practice (pp. 15.1-15.8). Kingston, NJ: Civic Research Institute.

Eldridge, H. (1997). Maintaining change: Relapse prevention for adult male perpetrators of child sexual abuse. Thousand Oaks, CA: Sage Publications.

Freeman-Longo, R. E., Bird, S., Stevenson, W., & Fiske, J. (1994). Nationwide survey of treatment programs and models: Serving abuse reactive children and adolescent and adult sex offenders. Brandon, VT: Safer Society Press.

Furby, L., Weinrott, M. R., & Blackshaw, L. (1989). Sex offender recidivism: A review. Psychological Bulletin, 105, 3-30.

Groth, A. N. (1978). Guidelines for the assessment and management of the offender. In A. W. Burgess, A. N. Groth, L. L. Holmstrom, & S. M. Sgroi (Eds.), Sexual assault of children and adolescents (pp. 3-24). Lexington, MA: Lexington Books.

Groth, A. N. (1979). Men who rape: The psychology of the offender. New York: Plenum Press.

Hanson, K., & Bussiere, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. Journal of Consulting and Clinical Psychology, 66, 348-362.

Kennedy, W. A., & Hume, M. P. (1998). Juvenile sex offender program reduces recidivism. The Brown University Child and Adolescent Newsletter, 14, 1-4.

Knight, R. A., & Prentky, R. A. (1992). Classifying sexual offenders: The development and corroboration of taxonomic models. In W. L. Marshall, D. R. Laws, & H. E. Barbaree (Eds.), Handbook of sexual assault: Issues, theories, and treatment of the offender (pp. 23-54). New York: Plenum Press.

Lanning, K. V. (1986). Child molesters: A behavioral analysis for law enforcement officers investigating cases of child sexual exploitation. Washington DC: National Center for Missing and Exploited Children.

Laws, D. R. (1989). Relapse prevention with sex offenders. New York: Guilford Press.

Mander, A. M., Atrops, M. E., Barnes, A. R., & Munafo, R. (1996). Sex offender treatment program: Initial recidivism study. University of Alaska at Anchorage: Alaska Justice Statistical Analysis Unit, Alaska Department of Corrections.

Marlatt, G. A., & George, W. H. (1990). Relapse prevention and the maintenance of optimal health. In S. A. Shumaker, E. B. Schron, J. K. Ockene, C. T. Parker, J. L. Probstfield, & J. M. Wolle (Eds.), The handbook of health behavior change (pp. 44-63). New York: Springer Publishing, Inc.

Marlatt, G. A., & Gordon, J. R. (Eds.). (1985). Relapse prevention. New York: Guilford Press.

Marques, J. (1970). Orgasmic reconditioning: Changing sexual object choice through controlling masturbation fantasies. Journal of Behavior Therapy and Experimental Psychiatry, 1, 263-270.

Marques, J. K., Day, D. M., Nelson, C., & West, M. A. (1993, August). Effects of cognitive-behavioral treatment on sex offender recidivism: Preliminary results of a longitudinal study. Paper presented at the Convention of the American Psychological Association, Toronto, Ontario.

Mayer, A. (1988). Sex offenders: Approaches to understanding and management. Holmes Beach, FL: Learning Publications.

Meiselman, K. (1978). Incest: A psychological study of causes and effects with treatment recommendations. San Francisco: Jossey-Bass.

Moore, D. L., Bergman, B. A., & Knox, P. L. (1999). Predictors of sex offender treatment completion. Journal of Child Sexual Abuse, 7, 73-88.

National Organization on Male Sexual Victimization (NOMSV), www.malesurvivor.org.

Nicholaichuk, T., Gordon, A., Gu, D., & Wong, S. (2000). Outcome of an institutional sexual offender treatment program: A comparison between treated and matched untreated offenders. Sexual Abuse: A Journal of Research and Treatment, 12, 139-153.

Olsen, S., & Aytes, K. (1997, July). Outcome evaluation of the Jackson County Sex Offender Supervision and Treatment Program, Jackson County Research and Evaluation Program. Unpublished paper presented to the Oregon Department of Corrections, Portland, OR.

Pithers, W. D. (1993). Treatment of rapists: Reinterpretation of early outcome data and exploratory constructs to enhance therapeutic efficacy. In G. Nagayama-Hall, R. Hirschman, J. R. Graham, & M. S. Zaragozee (Eds.), Sexual aggression: Issues in etiology, assessment, and treatment. (pp. 167-196). Bristol, PA: Taylor and Francis.

Pithers, W. D., & Hills, B. (1999). Empathy: Definition, enhancement, and relevance to treatment of sexual abusers. Journal of Interpersonal Violence, 14, 257-284.

Polizzi, D. M., Mackenzie, D. L., & Hickman, L. J. (1999). What works in adult sex offender treatment? A review of prison- and non-prison-based treatment programs. International Journal of Offender Therapy and Comparative Criminology, 43, 357-374.

Psychopathy exclusion from sex offender program upheld. (2000). Correctional Mental Health Report, 2, 45.

Reddon, J. R., Payne, L. R., & Starzyk, K. B. (1999). Therapeutic factors in group treatment evaluated by sex offenders: A consumer's report. Journal of Offender Rehabilitation, 28, 91-101.

Rice, M. E., Harris, G. T., & Quinsy, V. L. (1989). Sexual recidivism among child molesters. Research Report, 6, 4.

Rollnick, S., & Miller, W. R. (1995). What is motivational interviewing. Behavioural and Cognitive Psychotherapy, 23, 325-334.

Schwartz, B. K. (1995a). Theories of sex offenses. In B. K. Schwartz & H. R. Cellini (Eds.), The sex offender: Corrections, treatment and legal practice (pp. 2.1-2.32). Kingston, NJ: Civic Research Institute.

Schwartz, B. K. (1995b). Characteristics and typologies of sex offenders. In B. K. Schwartz & H. R. Cellini (Eds.), The sex offender: Corrections, treatment and legal practice (pp. 3.1-3.36). Kingston, NJ: Civic Research Institute.

Schwartz, B. K. (1998). Risk factors for recidivism among sex offenders. Unpublished manuscript.

Seto, M., & Barbaree, H. E. (1999). Psychopathy, treatment behavior, and sex offender recidivism. Journal of Interpersonal Violence, 14, 1235-1249.

Soukhanov, A. H., et al. (Eds.). (1992). American heritage dictionary of the English language (3rd ed.). New York: Houghton Mifflin Company.

Stoller, R. J. (1975). Perversions: The erotic form of hatred. New York: Pantheon Books.

Supreme Court again validates sexual predator laws. (2001). Juvenile Correctional Mental Health Report, 1, 33-48.

Tollinson, C. D., & Adams, H. E. (1979). Sexual disorders: Treatment, theory, and Research. New York: Gardner Press.

U.S. Department of Justice, National Institute of Corrections. (2001, March). Sex Offender Treatment Skills for Corrections Professionals. Televised series from Los Angeles County, California.

Wenger, P., West, M., & Hromas C. S. (Eds.). (2000). State sex offender treatment programs. Colorado Department of Corrections.

Zodhiates, S., (1990). The Hebrew-Greek key study bible: New American standard bible, Chattanooga, TN., AMG Publishers.

VITA

NAME:

Douglas A. Moorhead

EDUCATION:

| | | |
|---|---|---|
| Rosemead School of Psychology<br>Clinical Psychology | Psy.D. | (Cand.) |
| Rosemead School of Psychology<br>Clinical Psychology | M.A. | 1999 |
| Slippery Rock University<br>Guidance and Counseling | M.Ed. | 1993 |
| Penn State University<br>Psychology | B.S. | 1990 |

INTERNSHIP:

| | | |
|---|---|---|
| Huron Valley Center Psychiatric Hospital/Prison<br>Ypsilanti, MI | 2000 | - 2001 |

PRACTICA:

| | | |
|---|---|---|
| Agustus F Hawkins/Martin Luther King Jr. Hospital<br>Inpatient Program | 1999 | - 2000 |
| Biola Counseling Center<br>Outpatient Program | 1998 | - 1999 |
| Whittier Area Special Education Program<br>School Practicum | 1998 | |
| Franklin High School<br>School Practicum | 1993 | |

EMPLOYMENT:

| | | |
|---|---|---|
| Biola Counseling Center<br>Staff Therapist | 1999 | - 2000 |
| Hacienda-La Puente Unified School District<br>Drug, Alcohol, and Tobacco Education Interventionist | 1997 | - 1998 |
| Pennsylvania Department of Corrections<br>Corrections Counselor | 1993 | - 1996 |